

**THE CHRIST HOSPITAL
TRANSPLANT SOCIAL WORK
Pre-Transplant Social History
Donor Assessment**

(Please answer all questions. Each question is important, but no single question will rule you out as a donor. It is best to answer all questions honestly and completely as possible .)

Name: _____ DOB: _____
Address: _____ Email: _____
City: _____ Home phone: (____) _____ - _____
Zip: _____ Cell phone: (____) _____ - _____
Recipient/Relationship to you _____ Your citizenship _____

FAMILY/SOCIAL INFORMATION (Use back of page as needed)

Immediate Family

Marital Status: ___ Single ___ Married (If married, for how long? _____) ___ Separated ___ Divorced

Home status: Own _____ Rent _____ Household of another _____

Who lives in your home?

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Extended Family

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are the most common family conflicts within your immediate and/or extended family? _____

Early Life:

Where were you born and raised? _____

What was life like for you growing up. (Parents married? Divorced? Conflicts?)

How would you describe your "role" within your family growing-up? Circle one.

"The Responsible One", "The Black Sheep", "The Peacemaker", "The People-Pleaser", "The Invisible One", "The Joker",

Other _____ .

Did you experience significant loss as a child? (Death of parent? Grandparent? Close friend? Loss of friends due to changing schools?) _____

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Did you experience any traumatic incidents during childhood such verbal, physical or sexual abuse? _____

If yes, what happened? _____

What was school like for you most of time? _____

Were you in sports or other activities? _____

What was your favorite year of school? _____ Why? _____

Living Donation

Does the recipient know that you hope to donate? _____ If so, what was his/her response _____

How often do you have contact with the recipient? _____

What is the cause of the recipient's kidney failure? _____

Describe the changes in the recipient's life that you expect to see during the first year after transplant. _____

What other treatment options are available to the recipient? _____

Have you ever donated blood or done volunteer work? _____

What are your main reasons for wanting to donate?

1) _____

2) _____

How do you imagine your relationship with the recipient will change as a result of your donating? _____

What circumstances might cause you to change your mind about donating? _____

If you are able to donate, how will your life change as the result the recipient receiving your kidney? _____

If you were to decide not to donate how do you imagine your relationship with the recipient might change? _____

(**Note:** Should you change your mind, the recipient would not be told this by TCH Transplant staff.)

Do you feel confident in your decision to be worked-up as a potential donor? _____

Most donors have some reservations about donating during the early stages of their workup. Do you have any? _____

If so what are they? _____

What are your concerns about the medical and surgical risks involved in donating? _____

What are your concerns about the emotional and psychological risks involved in donating? _____

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How does your spouse or significant other (or parent) feel about your wish to donate? _____

Do you believe he/she understands the potential risks to your health as a result of your donating? _____

Do you have a Living Will? _____ If not, would you like assistance in completing one? _____

If you have religious beliefs, regardless of denomination or religion, how have these beliefs affected your decision to donate? For example, some people believe that because they have a strong faith in God and feel called to donate that the transplant surgery and recovery will go well. Please elaborate on any beliefs and/or faith you may have about donation. _____

Please list your biggest worries about donating?

1. _____
2. _____
3. _____

Post-Surgical Recovery Plan

Where will you stay once discharged from the hospital? _____

Who will drive you there? _____

Who will be your primary caregiver once you are discharged from the hospital? _____

Who will be your secondary caregiver? _____

If you have young children, who will look after them, get them to school, etc.? _____

Donors are typically off from work for 4-6 weeks. Will being off from work for several weeks create financial hardship for you? _____ Do you have FMLA? _____ Short term Disability? _____? If so, at what % _____

Who could you turn to for a loan if you needed financial help while you were off from work? _____

You will not be able to lift any thing weighing more than 10lbs for 6-8 weeks. Will this present a problem for you at work? _____ At home? _____ (Remember young children, pets, and household items can easily weigh more than 10lbs.)

Activities

Are you active in any clubs, religious or social organizations? If yes, please list:

1. _____ 2. _____
2. _____ 3. _____

What are your favorite things to do to relax and enjoy yourself?

1. _____ 2. _____
3. _____ 4. _____

Education/Employment

What was the last grade of school you completed? _____

Where did you go to school? High School _____ College/Grad School _____

Are you currently employed? _____ Yes _____ No

If yes, what is the name of your employer? _____

Please describe in detail what you do at work.

How long have you worked there? _____

Have you discussed donating with employer? _____ Yes _____ No

If yes, describe employer's response: _____

Do you have medical insurance? If so, what is it? _____

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Are you eligible for short-term disability? Yes No FMLA Yes No

Is your Spouse/S.O. employed? Yes No

If yes, where? _____

Medical Information

Name of your Primary Care Physician/Phone: _____ (____) _____

Please list all past surgeries: 1. _____ 2. _____
3. _____ 4. _____

Do you exercise regularly? If so, describe what you do and how often.

How well would you say that you cope with stress? Pretty well So So Not good at all

Describe a time in your life that was very stressful. What was going on? _____

What did you do to help yourself cope with the stress? _____

Lifestyle

Do you think you live a healthy lifestyle _____? How much water do you usually drink a day? _____

How many servings of fresh fruits and vegetables do you eat each day? _____?

What medicatin(s) do you usually take for minor aches and pain? _____

Do you smoke? Yes No If yes, how much? _____ If you smoked previously, when did you quit? _____

Do you drink alcohol? Yes No If yes, what is your drink of choice? _____

How many drinks per week on average? _____ Have you ever been treated for alcohol abuse? Yes No

Do you smoke marijuana? _____ If yes, how many times a day/week? _____

If you smoke marijuana regularly, would you be able to stop for four weeks prior to donation _____?

Have you ever misused prescription medicines? Yes No

Have you ever been treated for substance abuse? Yes No

On average, how many hours of sleep do you get per night? _____

Have you had any appetite changes within the past month. _____?

Have you ever been diagnosed with an eating disorder? Yes No If yes, please describe; include when and for how long you were bulimic, anorexic and whether or not you purged. _____

Are you currently being treated with medication for depression or anxiety? Yes No If so, why are they being prescribed? _____ Do they help? _____

Have you been diaganosed with a psychiatric illness? Yes No If yes, what is your current treatment?

_____ Have you seen a counselor, psychiatrist, or psychotherapist? Yes No If yes, when and for how long were you in treatment?

Please briefly describe the circumstances and whether you found it helpful. _____

Thank you for completing this form. Please sign and date.

Signature: _____ **Date** _____